❑ Initiate CMH Program services
❑ Service Modification
  □ Add a service
  □ Increasing level/hours of service
  □ Decreasing level/hours of service
❑ Change in Provider (requires 2 ISARs)
❑ End a service

CMH Program
Environmental Modification Services
Individual Service Authorization Request

Case Management/Transition Coordination agency

_____

Provider #

_____

Provider Name

Provider Number

Name: _____ Start Date: End Date:

Last, First MI

Medicaid Number: _____

The client must be receiving at least one other CMH Program service to receive this service.

CHECK SERVICE TO BE PROVIDED	COST	DMAS USE ONLY
☐ S5165 Environmental Mod; modifications only		
☐ 99199 U4 Environmental Mod; maintenance cost only		

Maximum Expenses = $5,000 per CSP year Note previous expenses this CSP yr: _____

Reason for the request: _____

Check the following as needed by the client:

☐ Physical adaptation of a house or place of residence necessary to assure a client's health & safety
☐ Physical adaptation of a house or place of residence which enable a client to live in a non-institutional setting and to function with greater independence
☐ Environmental Modification to a work site (which exceeds the requirements of ADA)
☐ Modification to the client's primary vehicle

☐ Rehabilitation Engineering (reason needed): _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this client. This service plan has been approved by the client and family/caregiver, as appropriate, and included in the CSP maintained in the transition coordination/case management record.

Transition Coordinator/Case Manager (print) Signature Phone No. Fax No. Date